Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite. 4T20
Atlanta, Georgia 30303-8909

October 7, 2003

Mr. Bob Sharpe
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, Florida 32308

Dear Mr. Sharpe:

We have reviewed your request to amend Florida's Home and Community Based Waiver for persons with Developmental Disabilities. This amendment request has been assigned control number 0010.91.R4, which should be used in all subsequent correspondence.

Based on the information and documentation furnished, we do not believe this application meets the statutory and regulatory requirements for approval. Please respond to the following questions:

1. Page 38, Item 3 – Adult Day Training: What is the justification for not including children for day training as in the current waiver?

2. Page 41, Item 7 - Specialized Mental Health Services: How are specialized mental health services coordinated with the behavioral assessments to enhance consistent treatment?

3. Page 73, Spousal Post Eligibility: Item (c) is not checked as in the current waiver. Please explain.

4. Appendix G-2 – Please check your calculations in Column E for all five years of the waiver. Our calculations, in the majority of instances, are different from yours. Please make the corrections where needed.

In addition, we are requesting that you respond to the following questions that will be asked on all HCBS waivers, renewals, or amendments that include a cost neutrality demonstration.

1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved State Plan/waiver.

To ensure that program dollars are used only to pay for Medicaid services, we are asking states to conform to CMS that providers retain 100 percent of the payments provided for in this HCBS waiver. Do providers retain all of the Medicaid payments (including regular and any supplemental payments) including the Federal and State share, or is any portion of any payment returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned to the State (i.e., general fund, medical services account, etc.).

2. Section 1902(a)(2)(1) provides that the lack of adequate funds from local sources will not result in the lowering the amount, duration, scope or quality of care and services available. Similarly, Olmstead Update #4, dated January 10, 2001, indicates that "States are not allowed to place a cap on the number of enrollees who may receive a particular service within a waiver." Please describe how the State share of each type of Medicaid payment in the financial estimates provided in the waiver (including regular and any supplemental payments) is funded. Please describe whether the State share is from appropriations from the legislature, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide State share. Please provide an estimate of total expenditures and State share amounts for each type of Medicaid payment. If any of the state share is being provided through the use of local funds using IGTs or CPEs, please fully describe the matching arrangement. If CPEs are used, please describe how the state verifies that the expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b).

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type in the waiver.

4. Does any public provider receive payments (including regular and any supplemental payments) that in the aggregate exceed the cost of services, does the State recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

Under Section 1915(f) of the Social Security Act, a waiver must be approved, denied or additional information requested within 90 days of receipt or the request will be deemed approved. The 90 day review period on this request ends October 15, 2003.

This request for information will, however, stop the 90 day clock. Once additional information is submitted to us, the 90 day clock will restart at day one.

If you have any questions regarding this waiver, please call Ronald Reed, Health Insurance Specialist, at (404) 562-7429.

Sincerely,

Ronald Reed
Health Insurance Specialist
Medicaid and SCHIP Policy Branch